AHCCCS CLAIMS CLUES

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INPATIENT OUTLIER CHANGES

Since the phase-in to the Medicare Urban or Rural rate is to be spread over 2 years, the CCR (cost to charge ratio) for qualifying a claim as outlier will still be hospital specific until fully phased in. Then, for dates of admission on and after 10/1/2009, there will be either an Urban or Rural CCR assigned to each hospital for outlier qualification.

Threshold calculation –
CURRENTLY – use the statewide outlier cost threshold
CHANGES – none, use the statewide outlier cost threshold

Outlier determination, does it qualify as an outlier? –
CURRENTLY – (Covered charges per day) multiplied by (hospital specific CCR). If this # exceeds the hospital Threshold for the qualified tier, the Claim qualifies as an outlier.
CHANGES – 10/1/2007 – 9/30/2008 – Dates of admission: (Covered Charges Per day) multiplied by (Hospital specific step 1 phase-in CCR, as provided by AHCCCS). If this # exceeds the Threshold for the qualified tier, the claim qualifies as outlier.

10/1/2008 – 9/30/2009 – Dates of Admission: (Covered Charges Per day) multiplied by (hospital specific step 2 phase-in CCR, as Provided by AHCCCS). If this # exceeds the Threshold for the Qualified tier, the claim qualifies as an outlier.

INPATIENT OUTLIER CHARGES cont.

10/1/2009 and > - Dates of Admission: (Covered Charges per day) multiplied by (Medicare Urban or Rural CCR, as provided by AHCCCS). If this # exceeds the Threshold for the qualified tier, the claim qualifies as an outlier.

Outlier Payment -

CURRENTLY – (Total Covered Charges) multiplied by (Statewide CCR (.4075))

CHANGES – 10/1/2007 – 9/30/2009 – Dates of admission: (Total Covered Charges) multiplied by (Medicare Urban or Rural based phase-in CCR, as provided by AHCCCS).

10/1/2009 and > - Dates of admission: (Total Covered Charges) multiplied by (Medicare Urban or Rural CCR, as provided by AHCCCS).

Effective with dates of admission 10/1/2007 and >, ROUTINE MATERNITY stays, any one-day stay with a delivery of one or two babies, will no longer be eligible for outlier consideration.

AHCCCS INTRODUCES "MYAHCCCS" ONLINE

MYahcccs.COM allows AHCCCS Members to register online to view and verify their own AHCCCS eligibility and enrollment information. You can visit the AHCCCS Member Website at **MyAHCCCS.com.**

IV HYDRATION, INFUSIONS AND INJECTIONS (CPT codes 90761 – 90779)

Several providers have asked AHCCCS to review our recent decision to deny separate payments for IV hydration, infusions and injections (CPT codes 90761-90779) under the AHCCCS Outpatient Fee Schedule (OPFS). After reviewing these requests, the basis for our original decision and information available from CMS, commercial payors and other sources, we are reaffirming our original decision. This is based on the following:

1) Professional Fees: The codes in question are all listed in the CCI edits as inclusive of all E&M codes, including those that describe professional services provided in the Emergency Department.
2) Facility Fees: The OPFS fee schedule for services provided in Emergency Departments and Outpatient Surgery departments bundles all services provided in those locations into a single facility fee. When AHCCCS developed the OPFS, we included all charges for services provided in those locations for various procedures during the base year. Thus, the facility fees established for services provided in either the ED or OP Surgery already include amounts previously charged separately for the services in question and no separate payment is necessary or warranted.

For the above reasons, AHCCCS will not make separate payments to professionals for hydration, infusions or injections when combined with a service described by an E&M code in any location and will not make separate payments to facilities under the OPFS for services provided in the Emergency Department or Outpatient Surgery. If there are any further questions, please do not hesitate to contact us.

PAPER CLAIM SUBMISSION

This is just a reminder that effective 10/1/2007, AHCCCS expected any fee for service providers (except Home and Community Based service providers and dental providers) submitting PAPER claims to AHCCCS to use only the “red forms”. This includes both UBs and 1500s. AHCCCS’ imaging system accepts the “red forms” with less manual intervention, less keying errors and more timely adjudication. Thanks so much for your cooperation.

AHCCCS FEE FOR SERVICE
CLAIMS CUSTOMER SERVICE UPDATE

AHCCCS is aware of the increase in response time to service calls from our providers. Your calls are important to us and it is our goal to respond in as timely a manner as possible. We want to take this opportunity to remind you of the options that are available to you when you utilize our website to status claims. The website is a great tool to identify claim status and any processing edits that apply to the claim. Be sure to review the edits option as well as denial reasons. This tool is available to you 24 hours a day, there is no hold time to speak to a representative, and you can receive the same detailed information that you need to resolve your claims quickly. https://azweb.statemedicaid.us.

ACUTE CARE HOSPICE

Effective October 1, 2007, AHCCCS has been authorized to expend funds to provide hospice services to non-ALTCS members 21 years of age and older. AHCCCS was previously authorized to cover members who were under age 21 or enrolled in ALTCS. Therefore, under new legislation, AHCCCS may offer Hospice services to all AHCCCS members.

ALTCS RECIPIENTS NOW ELEIGIBLE FOR LIMITED DENTAL COVERAGE

Effective October 1, 2007, ALTCS recipients age 21 and older may receive medically necessary dental services up to $1,000.00 per recipient per contract year (10/1 – 9/30). NOTE: Because emergency dental services are a separately identified covered service for all recipients, these services are excluded from the ALTCS Adult Dental Benefit.

COVERAGE OF DME IN THE HOSPITAL TIER RATE VS. SEPARATE PAYMENT

Payments for Durable Medical Equipment (DME) provided to AHCCCS members during inpatient hospital stays are generally included in the hospital tier rate payments. Under some circumstances, DME provided to AHCCCS members during inpatient stays may be billed separately by suppliers and paid by AHCCCS or its Contractors.

Any DME supplied to an AHCCCS member as part of the treatment the member receives during an inpatient hospital admission is included in the daily tier rate, even if on discharge the member takes the DME home for continued use. No separate payment for that DME may be made to the hospital or DME supplier by AHCCCS or its Contactors.

DME suppliers may submit separate claims for DME provided to an AHCCCS member while an inpatient in a hospital facility if the DME was provided to facilitate discharge of the member from the hospital and was neither necessary for nor used as part of the treatment the member received while an inpatient. In general, such equipment is provided close to the date of discharge and is not used in the hospital except to the extent necessary to achieve proper fit of the DME or training to assure its safe use upon discharge. In the absence of a showing to the contrary, DME provided to an inpatient more than two days prior to discharge is presumed to have been used as part of the treatment or recovery of the member during the hospital stay and may not be claimed separately by the hospital or DME supplier.

EFFECTIVE JANUARY 1, 2008, BILLING PROVIDERS ARE REQUIRED TO BILL WITH A BILLING NPI NUMBER

Dates of processing PRIOR to January 1, 2008

Any organization wishing to act as the financial representative for any provider or group of providers who have authorized this arrangement may register as a Group Billing provider.

Each service provider using the group billing arrangement must register as an AHCCCS provider and must sign a group billing authorization form. The authorization form is available from the AHCCCS Provider Registration Unit. The service provider's AHCCCS provider ID number must appear on each claim, even though a group billing number may be used for payment.

NPI requirements cont.

Each provider remains affiliated with the authorized group until the provider furnishes written notification to Provider Registration indicating termination of the group billing arrangement.

The following examples illustrate how claims would be processed and reimbursed in the specific situations:

Example:

Provider 111111-01 is in private practice and also works as a contract physician for a hospital. The hospital service provider ID# is 020000-01 and the hospital group billing ID# is 600000-01.

For services the provider furnishes in his/her private practice:

Provider ID# 111111-01 is entered in the PIN# section of Field 33 of the CMS 1500 claim form. The GRP# section of Field 33 will be blank. Reimbursement is sent to the physician's pay-to address.

For services the provider furnishes under contract to the hospital for which the hospital bills:

Provider ID# 111111-01 is entered in the PIN# section. The hospital billing ID# 600000-01 is entered in the GRP# section. Reimbursement is sent to the hospital's group biller pay-to address.

Dates of Processing On and After January 1, 2008

In addition to allowing any organization wishing to act as a financial representative for any provider or group of providers who has authorized this arrangement to register as a Group Biller with AHCCCS (and receive a separate Group Billing AHCCCS registration number), the billing provider process has been modified to allow a service provider to act as a financial representative for another single service provider or a group of service providers. Providers who act in or participate in this capacity are still required to register with AHCCCS and sign a group biller authorization form.

Each service provider using either billing provider arrangement (as noted above) must register as an AHCCCS provider and must sign a Billing Provider Authorization Form. The authorization form is available from the AHCCCS Provider Registration Unit. The service (rendering) provider's NPI number must appear on each claim, even though a billing provider NPI (as noted above) may be used for payment.

NPI requirements cont.

Each service (rendering) provider remains affiliated with the authorized billing provider arrangement until the service (rendering) provider furnishes written notification to Provider Registration indicating termination of the billing arrangement.

If the provider has multiple locations, the provider may have multiple billing provider associations.

The following examples illustrate how claims would be processed and reimbursed in the specific situations:

Example:

Dr. Jones is registered as a Physician under NPI# 9999999999. Dr. Jones has a Physician Assistant that is also registered with AHCCCS and rendering services under NPI# 1111111111.

For services rendered by the Physician:

Dr. Jones will complete Field 33 with NPI# 9999999999. Reimbursement is sent to providers pay-to address.

For services rendered by the Physician Assistant being billed by the Physician:

The Physician's Assistant will insert the NPI# 1111111111 in Field 33 under the PIN#. Dr. Jones' NPI# 9999999999 will also show in Field 33 under the GRP#. Reimbursement will be payable and delivered to Dr. Jones' pay-to-address.

BILLING OF OUTPATIENT HOSPITAL CLAIMS

AHCCCS reimburses in-state, non-HIS hospitals for outpatient services billed on a UB claim form using the AHCCCS Outpatient Hospital Fee Schedule. The Outpatient Hospital Fee Schedule will provide rates ate the procedure code level, and Surgery/Emergency Department (ED) services will be bundled similar to Medicare for payment purposes. AHCCCS also utilizes the Outpatient Hospital CCI edits when processing these claims.

The Claims Department has recently noticed an increase in Hospitals "split billing" outpatient services. If the provider is billing outpatient services for the same member, same date of service, all services for that outpatient visit (regardless of Revenue Code being billed) should be billed as one claim. A second claim (split billed) for the same date of service from the same provider will automatically deny as a duplicate claim. Please refer to Chapter 11 of the Fee for Service Claims and Policy Manager for additional clarification.